



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

WAYNE A SOIGNIER, MD
10109 MCKALLA PLACE, STE E
AUSTIN, TX 78758

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-4873-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The explanation given on the EOB justifying the reduction states" TYPE OF EXAMINATION WAS NOT REQUESTED (REFER TO DWC 22 OR DWC 32), however, this is incorrect. I have attached a copy of both the DWC 32 and the DDLOC showing where Return to Work (RTW) was ordered. The reduction of parts of this claim is in violation of the Texas Department of Insurance Division of Workers' Compensation as this service was ordered on the DWC-32."

Amount in Dispute: \$250.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...the DWC-69 is silent on the return to work issue."

Response Submitted by: Texas Mutual Insurance Co, 6210 E. Hwy 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 21, 2011	99456-W8-RE	\$250.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
Explanation of benefits dated May 04, 2011
- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
 - 748 – TYPE OF EXAMINATION WAS NOT REQUESTED (REFER TO DWC 22 OR DWC 32).
- Explanation of benefits dated August 08, 2011.
- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
 - CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
 - 748 – TYPE OF EXAMINATION WAS NOT REQUESTED (REFER TO DWC 22 OR DWC 32).
 - 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION.

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement for disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The requestor was ordered by the Division to perform an examination to address multiple EMC/RTW type questions, of which one was the injured workers' Return to Work status per the DWC-32 and the Letter of Clarification. The requestor billed the amounts of \$250.00 for CPT code 99456-W8-RE for a DD examination for Return to Work (RTW). Review does not support that any RTW examination was documented in the narrative. While the requestor is correct that the examination was ordered and there is a DWC-73 Work Status form submitted with Part II, box b. checked, the exam itself is not mentioned or addressed in the narrative. Therefore, the billing for 99456-W8-RE is not reimbursable as it is not properly documented.
2. The respondent is not entitled to additional reimbursement for undocumented services.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the disputed services.

Authorized Signature

_____	_____	February 09, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a *certificate of service demonstrating that the request has been sent to the other party*.**
Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.